

## AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name:		Date of Birth:	
Social Security Nu	ımber:	Date:	
REBY REQUEST A	ND GIVE AUTHORI	TY TO PREMIERE OB/GYN TO OBTAIN A COPY OF MY ME RECORD FROM:	
Physician/Hospi	ital/Other:		
Address:			
	41	a A	
Fax:		Phone:	
I HER	EBY REQUEST A CO	OPY OF MY MEDICAL RECORD BE RELEASED TO:	
		Premiere Ob/Gyn 1150 N. 35 <sup>th</sup> Avenue, Suite 405	
¥2.	Phone:	Hollywood, Florida 33021 (954) 961-9993 / Fax: (954) 961-0163	
	PATIENT TO DE	ESIGNATE RECORD(S) TO BE RELEASED:	
> ×		I agree that any and all medical information may	
Patient Signature		released, including but not limited to mental hea drug or alcohol use, HIV/AIDS test results and ot	
oew f	÷ ,	records protected by state and federal laws.	
*	*** **	I request that the release of medical information	
Patient Signature		restricted to the following portions of my medica	
	2 50 G	record:	
* ;			
8	e.		
** }			
l understand	d that this authorize	ation is valid for 60 days from the date of my signature.	
,	w yes	Date:	
Patient or Paren	t/Legal Guardian S		
		a g	

Memorial Regional 1150 N. 35th Ave., Ste. 405 Hollywood, FL 33021 (954) 961-9993 • Fax (954) 961-0163 Memorial West 601 N. Flamingo Rd., Ste. 401 Pembroke Pines, FL 33028 (954) 961-9993



## **AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**

Patient Signature released, including but no drug or alcohol use, HIV/A	N 1	
COPY OF MY MEDICAL RECORD TO:  Physician/Hospital/Other:  Address:  Phone:  PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m Patient Signature  Patient Signature  released, including but no drug or alcohol use, HIV/A	Date:	
Fax:Phone:  PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m Patient Signature released, including but no drug or alcohol use, HIV/A	B/GYN TO RELEASE A	
PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m  Patient Signature released, including but no drug or alcohol use, HIV/A	- N - N - N - N - N - N - N - N - N - N	
PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m  Patient Signature released, including but no drug or alcohol use, HIV/A		
PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m  Patient Signature released, including but no drug or alcohol use, HIV/A		
PATIENT TO DESIGNATE RECORD(S) TO BE RE  I agree that any and all m released, including but no drug or alcohol use, HIV/A	A 52	
records protected by stat	edical information may be t limited to mental health IDS test results and other	
Patient Signature I request that the release restricted to the following record:	of medical information be g portions of my medical	
I understand that this authorization is valid for 60 days from theDate:	date of my signature.	
Patient or Parent/Legal Guardian Signature		
Date: _		

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